Asiah bte Kamsah v Dr Rajinder Singh & Ors

HIGH COURT (IPOH) — CIVIL SUIT NO 21-47 OF 1991
JAMES FOONG J
20 JULY 2001

***Tort** — Assault — Consent — Patient suffered injuries after surgery — Written consent for surgery not found — Evidence of witnesses considered — Whether consent for surgery given — Whether assault proved*

***Tort** — Negligence — Professional negligence — Medical practitioner — Anesthetist — Patient suffered injuries after surgery — 'Bolam' test applied — Standard of practice accepted by responsible body of skilled medical men — Short fall in post operative care of patient — Whether negligence proved*

The plaintiff (suing through her brother and next of friend) was admitted to the Telok Intan District Hospital ('the hospital') to deliver her second child on 10 October 1988. Due to suspicion of fetus distress, she underwent a lower section caesarian operation ('LSCS') conducted by one Dr Karamjeet Singh with the approval of the first defendant, Dr Rajinder Singh, the gynecologist of the hospital at that time. For this operation, she went under general anesthesia applied by the second defendant. Though the operation was successful with the delivery of a baby boy, the plaintiff did not fully recover from the operation. She suffered permanent irreversible brain damage. For her injuries, the plaintiff was claiming damages against the defendants based on two causes of action, ie assault and negligence.

Held, dismissing the claims against the first and third defendants, and finding the second defendant liable for negligence, thus rendering the fourth defendant vicariously liable thereof:

(1) The plaintiff could not render any evidence to support her claim in view of her present mental condition. So the court was firstly deprived of the grantor of consent's evidence: whether she did consent or refused such surgery. When the best evidence was absent, the court had to move on to examine the circumstantial evidence. Under such emergency situation, the court did not suspect that the plaintiff did not give her consent to the operation and believed the two doctors on their positive assertions that consent for the operation in a written form was seen by them before surgery on the plaintiff was carried out. Just because such a form was not found in the hospital file did not necessarily prove that there was no consent given by the patient. All relevant evidence must be taken into consideration and in this case, after due evaluation, the court found that such written consent by the plaintiff existed before the operation. Thus, the allegation of assault against the defendants must fail (see p 489A–E).

(2) Despite extensive cross examination of Dr Karamjeet Singh by plaintiff's counsel, there was no evidence to support a finding that the doctor was negligent in the surgery according to the test set out in the established case of *Bolam v Friern Hospital Management* [1957] 2 All ER 118. The plaintiff must have concurred with this since there was absolutely no reference in the plaintiff's submission commenting on the negligent act of this particular doctor. When Dr Karamjeet was not liable for any negligent act relating to the surgical aspect of the plaintiff then the first defendant, as head of the gynecological department of the hospital and the person who gave the approval to Dr Karamjeet Singh to proceed with the LSCS operation on the plaintiff, should not be liable vicariously (see p 489G–I).

(3) Post operative treatment resulting from anaesthesia was the responsibility of the second defendant as the anesthetist in this case. However, the defendants' own witness, DW5 admitted that there was a short fall in the post operative care of the patient. The court thus found that the second defendant guilty of negligence since he did not act in accordance with the practice accepted as proper by a responsible body of medical men skilled in this particular art — a test as set forth in *Bolam*'s case (see p 494E–G).

(4) There was no evidence to prove that the third defendant had been personally liable for the injuries of the plaintiff nor was the hospital, for which the third defendant was the superintendent, proved to be negligent or had assaulted the plaintiff. Against the second defendant, the cause of action for negligence was proven, but not that of assault. As the second defendant at that material time of the accident was an employee of the fourth defendant, the fourth defendant was vicariously liable to the plaintiff for negligence (see p 494H–I).

(5) For pain, suffering and loss of amenities, the court awarded a sum of RM200,000 for general damages. For special damages, the court awarded RM96,242.90 and RM76,650 for pre trial and post trial expenses respectively plus interest (see p 495B–G).

[Bahasa Malaysia summary

Plaintif (menyaman melalui abang beliau dan sahabat wakil) telah dimasukkan ke Hospital Daerah Telok Intan ('hospital tersebut') untuk melahirkan anak kedua beliau pada 10 Oktober 1988. Disebabkan rasa syak kecemasan janin, beliau menjalani satu pembedahan caesarian bahagian bawah ('PCBB') yang dikendalikan oleh Dr Karamjeet Singh dengan kebenaran defendan pertama, Dr Rajinder Singh, ginakologi hospital tersebut pada masa itu. Untuk pembedahan ini, beliau diletak di bawah anestesia am yang dikendalikan oleh oleh defendan kedua. Walaupun pembedahan tersebut berjaya dengan kelahiran seorang bayi lelaki, plaintif tidak

sedar sepenuhnya daripada pembedahan tersebut. Beliau mengalami kecacatan otak kekal yang tidak boleh dipulihkan seperti keadaan sedia kala. Untuk kecacatan beliau, plaintif menuntut ganti rugi terhadap defendan-defendan berdasarkan dua kausa tindakan; iaitu serangan dan kecuaian.

Diputuskan, menolak tuntutan-tuntutan terhadap defendan-defendan pertama dan ketiga, dan mendapati defendan kedua bertanggungjawab untuk kecuaian, oleh itu menyebabkan defendan keempat bertanggungjawab secara vikarius:

(1) Plaintif tidak dapat mengemukakan apa-apa keterangan untuk menyokong tuntutan beliau memandangkan keadaan mental beliau sekarang. Oleh itu mahkamah pertamanya kehilangan keterangan orang yang telah memberikan kebenaran tersebut: sama ada beliau memang telah membenarkan atau menolak pembedahan tersebut. Apabila keterangan terbaik tiada, mahkamah akan beralih untuk memeriksa keterangan mengikut keadaan. Di dalam keadaan kecemasan tersebut, mahkamah tidak mensyaki bahawa plaintif tidak memberikan kebenaran beliau untuk dibedah dan mempercayai kedua-dua doktor tersebut berdasarkan penegasan positif mereka bahawa kebenaran untuk pembedahan tersebut atas borang bertulis telah dilihat oleh mereka sebelum pembedahan ke atas plaintif dilakukan. Hanya semata-mata kerana borang tersebut tidak dapat ditemui dalam fail hospital tersebut tidak semestinya membuktikan bahawa tiada kebenaran telah diberikan oleh pesakit. Semua keterangan yang berkaitan mestilah diambilkira dan dalam kes ini, setelah diteliti, mahkamah mendapati bahawa terdapat kebenaran bertulis tersebut oleh plaintif sebelum pembedahan tersebut. Oleh itu, dakwaan serangan terhadap defendan-defendan mesti gagal (lihat ms 489A–E).

(2) Meskipun pemeriksaan balas terperinci dijalankan ke atas Dr Karamjeet Singh oleh peguam plaintif, tiada keterangan untuk menyokong penemuan bahawa doktor telah cuai dalam pembedahan mengikut ujian yang dinyatakan dalam kes yang terkemuka *Bolam v Friern Hospital Management* [1957] 2 All ER 118. Plaintif mestilah telah bersetuju dengan ini kerana tiada rujukan langsung dalam penghujahan plaintif mengkomen tentang tindakan cuai doktor yang berkaitan ini. Tatkala Dr Karamjeet tidak bertanggungjawab untuk apa-apa tindakan kecuaian berhubung aspek pembedahan plaintif, maka defendan pertama, sebagai ketua bahagian ginakologi hospital tersebut dan orang yang memberikan kebenaran kepada Dr Karamjeet Singh untuk meneruskan PCBB ke atas plaintif, sepatutnya tidak bertanggungjawab secara vikarius (lihat ms 489G–I).

(3) Rawatan selepas pembedahan yang diakibatkan oleh anestasia adalah tanggungjawab defendan kedua sebagai pakar anestasia

dalam kes ini. Namun begitu, saksi defendan-defendan sendiri, DW5 telah mengaku bahawa terdapat kekurangan dalam rawatan selepas pembedahan pesakit tersebut. Maka mahkamah mendapati bahawa defendan kedua bersalah kerana cuai memandangkan beliau tidak bertindak menurut amalan yang diterima sebagai yang betul oleh sekumpulan pakar perubatan dalam bidang khusus ini — satu ujian yang dinyatakan dalam kes *Bolam* (lihat ms 494E–G).

(4) Tiada keterangan untuk membuktikan bahawa defendan ketiga bertanggungjawab secara peribadi terhadap kecacatan plaintif maupun hospital tersebut, di mana defendan ketiga merupakan penguasa, yang dibuktikan telah cuai dan menyerang plaintif. Terhadap defendan kedua, kausa tindakan untuk kecuaian telah dibuktikan tetapi bukan untuk serangan. Memandangkan defendan kedua pada masa matan kemalangan tersebut adalah seorang pekerja defendan keempat, defendan keempat adalah bertanggungjawab secara vikarius kepada plaintif kerana kecuaian tersebut (lihat ms 494H–I).

(5) Untuk kesakitan, kesengsaraan dan kehilangan kemudahan, mahkamah mengawardkan sejumlah RM200,000 untuk ganti rugi am. Untuk ganti rugi khas, mahkamah mengawardkan RM96,242.90 dan RM76,650 untuk perbelanjaan pra perbicaraan dan selepas perbicaraan masing-masing berserta faedah (lihat ms 495B–G).]

Notes

For cases on assault generally, see 12 *Mallal's Digest* (4th Ed, 2000 Reissue) paras 5–10.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2000 Reissue) paras 798–849.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (folld)

Hira Singh (*Anit Kaur* with him) (*Asbir Hira Singh & Co*) for the plaintiff.
Raja Rozela bte Raja Toran (Federal Counsel) for the defendants.

James Foong J:

INTRODUCTION

The plaintiff (suing through her brother and next of friend) is a Malay lady of thirty years of age when she was admitted to the Telok Intan District Hospital ('the hospital') to deliver her second child on 10 October 1988. Due to suspicion of fetus distress, she underwent a lower section caesarian operation ('LSCS') conducted by one Dr Karamjeet Singh with the

approval of the first defendant, Dr Rajinder Singh, the gynaecologist of the hospital at that time. For this operation, she was under general anesthesia applied by the second defendant. Though the operation was successful with the delivery of a baby boy, the plaintiff did not fully recover from the operation. She suffered permanent irreversible brain damage.

Her condition as described by one Dr Fadzli Cheah, a consultant neurosurgeon, who examined her towards the end of 1999, is one of:

> ... severe permanent mental deficit, cortical blindness and severe spastic quadriparesis. As such, (she) has been rendered totally and permanently disabled requiring complete nursing care at home.

THE PLAINTIFF'S CLAIM

For her injuries, the plaintiff is claiming damages against the defendants. It is based on two causes of action: assault and negligence. Against the first defendant for the vicarious liability of the surgeon, Dr Karamjeet Singh, who performed the LSCS operation on her. Against the second defendant, for his role as an anesthetist in the operation. Against the third defendant, as superintendent of the hospital. Since all these defendants were government servants at that material time, the fourth defendant is inserted as a party to this action.

DEFENCES

The defendants' defences are denials to both assault and negligence.

Assault

I shall first deal with the cause of action of assault. This arose from the allegation of the plaintiff of there being an absent of consent given by her for the LSCS operation.

In an operation of this nature, the defendants have not denied that it was the practice of the hospital at the material time to obtain a written consent from the patient before surgery was carried out. If the patient was incapable to give such consent then this would be secured from the nearest relative.

But in this case, the written consent of the plaintiff or her closest relative for the LSCS operation was not produced. Only a consent by the plaintiff for a lumber puncture was tendered.

Though Dr Karamjeet Singh and the second defendant have insistently maintained that they have personally seen such a consent signed by the plaintiff before commencement of the operation, this document is just not around in the hospital file. Thus, was there any consent given?

This allegation on the absence of consent to justify a claim by the plaintiff for assault was not in the original plaintiff's statement of claim. This was added during the course of trial when it was discovered that such a document was not contained in the hospital file. Seizing upon this shortcoming, the plaintiff's counsel mounted this cause of action. But to

succeed in such a claim, one must not lose sight that the burden of proof is always with the plaintiff. In this case, the plaintiff could not render any evidence to support her claim in view of her present mental condition. So we are firstly deprived of this grantor of consent's evidence: whether she did consent or refused such surgery.

When the best evidence is absent we move on to examine the circumstantial evidence. From all the witnesses summoned by the plaintiff, none of them testified positively that the plaintiff had not given her consent for the operation. PW4, the scrub nurse who said that the operation went without such consent based her testimony solely on the absence of such written consent found in the hospital document. She did not affirm that the plaintiff never gave her consent. In fact, we have evidence from most quarters that if the operation had not been performed, the plaintiff's uterus would have ruptured, caused by fetus distress, leading to profuse bleeding and ultimate death of the plaintiff. Under such emergency situation, I do not suspect that the plaintiff did not give her consent to the operation. I believed the two doctors — Dr Karamjeet Singh and the second defendant on their positive assertions that consent for the said operation in a written form was seen by them before surgery on the plaintiff was carried out. Just because such a form is not found in the hospital file does not necessarily prove that there was no consent given by the patient. All relevant evidence must be taken into consideration and in this case, after due evaluation, I find that such written consent by the plaintiff existed before the operation. For this, the allegation of assault against the defendants must fail.

Negligence

First defendant

I shall now move on to the arena of negligence commencing with the allegation against the Dr Karamjeet Singh. Though this particular doctor is not named as a party to this suit but his superior, the first defendant is, based on the assertion that the first defendant authorized Dr Karamjeet Singh to carry out such surgery. Thus, for the purpose of determining vicarious liability, the acts of Dr Karamjeet Singh during this operation must be considered.

Despite extensive cross examination of Dr Karamjeet Singh by plaintiff's counsel, I find no evidence to support a finding that this doctor was negligent in this surgery going by the test set out in the established case of *Bolam v Freirn Hospital Management Committee* [1957] 2 All ER 118. The plaintiff must have concurred with this since I find absolutely no reference in the plaintiff's submission commenting on the negligent act of this particular doctor.

When Dr Karamjeet is not liable for any negligent act relating to the surgical aspect of the plaintiff then the first defendant, as head of the gynecological department of the hospital and the person who gave the approval to Dr Karamjeet Singh to proceed with the LSCS operation on the plaintiff, should not be liable vicariously.

Second defendant

In the surgical operation performed on the plaintiff, the second defendant was the anesthetist who applied general anesthesia on her. This process, as told by the experts who testified in this trial and accepted by the second defendant involved three stages: induction, maintenance and reversal. Professor Delikan ('PW9') from the Department of Anaesthetic of the University Hospital, University of Malaya drew analogy of this to an aircraft on a flight. The initial stage is the preparation for the patient off on an air ride. Once on flight, the anesthetist should maintain the patient; the patient would be on auto pilot. This is the period when the surgical operation can be performed without the patient being aware of it. When this is over, the patient has to be recovered from the effects of anesthesia. This, the learned professor likens to a touch down of the airplane. To decide on the issue of liability, I shall examine the different stages undertaken by the second defendant on the plaintiff.

At the commencement of the induction stage, the second defendant administered pure oxygen into the plaintiff for three minutes. This was to boost her reserve as a pregnant woman, with a full stomach, often experiences a lower supply of oxygen. Subsequent to this, a drug — sodium thiopentone — was applied to render her unconscious. When she was knocked off, another agent — suxamethonium was injected. This was to relax her muscles. For this agent to take effect the second defendant waited for 60 seconds. Once effected, the plaintiff would not be able to breathe on her own. This was necessary for the purpose of intubating an endotracheal tube ('ETT') into her trachea to connect her to the anesthesia machine. Once the ETT was felt to be in place, the second defendant commenced to pump manually gas from the anesthesia machine into the plaintiff. The gas consisted of a mixture of oxygen and nitrous oxide. While at this, the second defendant was also listening through a stethoscope to the performance of the plaintiff's lung. At this stage, he felt tightness on the pump. This is an indication that the gas was not entering the plaintiff. There was resistance. 'After several moments' later, he noticed the plaintiff was slightly bluish. Similar sign also appeared in the plaintiff's fingertips. Her heart rate was also getting slower. She was suffering from cyanosis which is caused by the lack of oxygen (hypoxia) in the human body. If allowed to persist for too long the brain might swell leading to brain damage. Immediately, according to the second defendant, he administered intravenously a drug called atropine. This drug would speed up the plaintiff's heart beat. Besides, he turned off the nitrous oxide in an attempt to allow 100% oxygen to enter the plaintiff's lung. Next, he checked the ETT to ensure that it was in the correct place and/or it had not slipped or kink. This was performed manually and with the assistance of laryngoscope — a tube with a light attached to the end, to be pushed into the trachea. He discovered constriction in the small airways. The term to describe this is: bronchospasm. It simply means that the broncho (the breathing tube of the body) had gone into spasm (narrowing), thus, preventing gas from the anesthesia machine from going into the plaintiff's lung. Upon discovering this, the second defendant administered a second drug called aminophyline

A This was to relief the constriction in this small area. And, according to him, within several seconds the plaintiff returned to pink with heart rate beating at satisfactory. With these positive indications, he requested Dr Karamjeet Singh to proceed with the operation.

After surgery was completed, the second defendant reversed the
B plaintiff. This was by way of two drugs — neostigmine and atropine. When these had taken effect, he gave brief commands to which the plaintiff open her eyes. Once satisfied that the plaintiff was breathing on her own, the ETT was removed. With the plaintiff's pulse and heart rate reading at acceptable level and her oxygenation being adequate, instruction was given by the second defendant to transfer the plaintiff to the adjoining recovery
C room. There she remained for approximately 20 minutes before she was given the go ahead to return to the post natal ward.

A nurse from the post natal ward, PW5, came to collect the plaintiff from the recovery room. Upon seeing the plaintiff, PW5 was dissatisfied with her condition. She observed that the plaintiff, though able to open her
D eyes but her stares were blank. The plaintiff was in a state of stupor. Besides, her hands were stiff. This nurse initially refused to receive her but upon being informed by the recovery room nurse that the second defendant has certified the plaintiff's discharge to the ward she reluctantly pushed the plaintiff off with a protest that she should not be held responsible for any untoward eventualities that may befall upon the plaintiff.

E At the ward, still feeling uncomfortable with the plaintiff's condition, PW5 contacted Dr Karamjeet Singh, who in turn requested the presence of the second defendant. After both these doctors had viewed the plaintiff, she was sent from the post natal ward to the ICU. There she remained under the charge of the second defendant for two days. Nothing much was done
F to the plaintiff in the ICU, except observation and assessment. According to the second defendant, the plaintiff was less responsive than the time he discharged her to the recovery room.

After two days the plaintiff was once again returned to the post natal ward without her condition improving. An entry in the hospital notes states: 'Refer to psychiatrist — ? Depression.'

G

Then on the 29 October 1988, the plaintiff was send to the Neurology Department of the General Hospital at Kuala Lumpur where she was treated but her result was not encouraging. With some slight improvement she returned to the hospital on the 12 December 1988 until she was finally discharged on the 23 December 1988.

H

Causation

Dr Fadzli Cheah who examined the plaintiff on her current condition has confirmed that it was caused by 'severe diffused injury to the brain'. The second defendant has also admitted in his evidence that when he saw the
I plaintiff at the ICU she had brain damage. The second defendant then continued to confirmed that 'she (the plaintiff) suffered complication with anesthetic resulted in some degree of brain damage. Thus, she was not able

to return to the post operative stage'. With this, I am satisfied that the plaintiff's condition is caused at her operation during anaesthesia stage. A

Considerations

In the light of these facts, the plaintif's counsel insist that the second defendant was negligent at the induction and reversal level of anaesthesia associated with post operative care. B

Induction stage

At the induction stage, Mr Hira Singh and Ms Anit Kaur, counsel for the plaintiff impressed upon me that the second defendant had taken longer than an anesthetist of similar experience and standing as the second defendant at that material time to relieve the plaintiff of hypoxia. The two to three minutes from time of detection of the problem to eventual relief as claimed by the second defendant was challenged. The basis is as follows: Firstly, the second defendant had to wait for one full minute before suxamethonium (the drug which relaxes the muscles) could work. Then, upon discovering cyanosis (discoloring of the body) which could only have been after the initial one minute for suxamethonium to take effect, time was taken by the second defendant to discover bronchospasm. This must have consumed a good one minute. Upon discovering bronchospasm, the drug administered — aminophyline, which had to be injected slowly according to the second defendant's own evidence, took one to two minutes to act (though Prof Delikan insists that for this agent to react it takes five to ten minutes). Thus, the total time consumed by the second defendant could never have been two to three minutes even taking the higher time scale of two minutes (as compared to Prof Delikan's) for aminophyline to react. C D E F

It is essential to bear in mind that this patient was a pregnant woman. Her tolerance to lack of oxygen was less than four minutes. By the time cyanosis was discovered she was already deprived of one minute of oxygen. Presume the time taken to discover bronchospasm was another minute, two minutes had passed. The administration of aminophyline would have knock off a few seconds and for it to act, taking the higher scale of time opine by the second defendant of two minutes to the insistence of Prof Delikan of five to ten minutes, this would have absorbed a total of four minutes past. Well past the time limit for the plaintiff to survive without suffering from brain swelling, a secondary of hypoxia, which causes certain degree of brain damage. In fact through persistent cross examination of the second defendant, the second defendant has admitted that from the time he administered suxamethonium to the time he corrected the problem, the period taken was 'four to five minutes'. This, his said 'is my estimate'. Similarly, the defence own expert witness, DW5, has to concede under cross examination that second defendant may not be correct when he said that he took two to three minutes from time of detection to time of relief. 'I believe two to three minutes is when Dr Siva ('second defendant') identified the problem' he continued. G H I

Though the second defendant did not make the deadline to prevent the effects of hypoxia but was he negligent? Under the *Bolam* test (per McNair at p 122):

> A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art ... [a] man need not possess the highest at the expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises ordinary skill of an ordinary competent man exercising that particular art ... in the case of a medical man negligence means failure to act in accordance with the standard of reasonably competent medical man at that time ... there may be one or more perfectly proper standards; and if a medical man conforms with one of these proper standards then he is not negligent.

Undoubtedly, anaesthetic is a special branch of medicine. The second defendant, though possessing no special paper qualification at that material time except that of a MBBS degree, had undergone training to give anesthesia for four to five months at the Ipoh General Hospital. Thereafter he was doing cases on his own. After 16 months at Ipoh General Hospital, where he was trained as an anesthetic and practiced as one, he was transferred to the hospital. Such in house training according to Director of Health in the State of Perak, PW7, was sufficient to permit the second defendant to provide anesthesia during an operation. When the second defendant was considered competent to practice this art, then the second defendant's action in this operation must be considered in the light of what a reasonably competent anesthetist would have done during the induction stage of the said operation?

As to the technique applied and drugs administered, from the evidence adduced by the specialist in this field, I do not consider the second defendant has not done what a reasonably competent anesthetist would have done. Though Prof Delikan had insisted that another liquid inhalation agent known as halothane should have been inserted to relief the bronchospasm, I feel that this is only another technique. But more important to these is the time factor on the application of the technique and administration of the relevant drugs. It was quite pointless to proceed applying the right procedure when there was insufficient regard to time. And this case, time was of the essence. As DW5 candidly admits: 'During these few minutes the anesthetist must be quick in mind and action'. The patient was running low on oxygen and cyanosis was experienced by the plaintiff. Though the second defendant may not have at that stage suspected the plaintiff to suffer bronchospasm, he should have being aware, as an anesthetist, that aminophyline, the agent to relieve such constriction takes time to be effective. When this was the constraint he should 'be quick in mind and action' to discover the cause and apply the said drug immediately. This, from the accepted standard of practice, I find the second defendant had failed to carry out within this short but critical period.

Reversal stage associated with post operative care

Instead of sending the plaintiff to the ICU after her reversal from anesthesia, the second defendant discharged her from the recovery room to the post

natal ward. Was this an accepted standard and practice in view of the plaintiff's condition then? Though signs of successful reversal from anesthesia was from responses of patient, such as the plaintiff opening her eyes upon command, breathing on her own satisfactorily, and other vital signs being positive, her general condition was not acceptable. She could not lift her head and her blank stares of a stupor manner should warrant the second defendant to admit the plaintiff to the ICU. Though the ability to lift her head may not be a criteria of abnormality because many patients do suffer intense pain after surgery and were unable to lift their heads, the plaintiff's general condition was just not right. Added to this, hypoxia was experienced by the plaintiff during induction. As DW5 said:

> When one suffers from this (hypoxia) which could lead to cerebral oedema (brain swelling) it would be best to send her to ICU to minimize the effect of cerebral oedema. Sending her to the general ward would have made her condition worse. In ICU, for a patient who had undergone hypoxia in 1988 she would have to be artificially ventilated for 48 hours to minimize the effect of brain swelling ... follow up treatment would include treatment to control intra cerebral pressure for a period of time ... If the MO (medical officer) lacks knowledge and expertise in any area he should have consulted the consultant. The consultant specialist in the state would know how to follow up such treatment if matter was referred to him.

This is also the views of Prof Delikan. But unfortunately, though admitted to the ICU for 48 hours, no follow up treatment was administered, nor the state anesthetist consultant consulted. The plaintiff's condition had certainly worsened as can be gauged by the second defendant's own observation that the plaintiff at the ICU was less responsive than when he saw her at the recovery room.

Post operative treatment resulting from anaesthesia was the responsibility of the second defendant as the anesthetist in this case. 'However' as admitted by the defendants' own witness, DW5, 'there was a short fall in the post operative care of the patient'. When this was the situation, I find that the second defendant is guilty of negligence since he did not act in accordance with the practice accepted as proper by a responsible body of medical men skilled in this particular art — a test as set forth in *Bolam*'s case.

FINDING ON LIABILITY

Based on the aforesaid, I hereby firstly dismiss the plaintiff's claim against the first defendant. Further, I also dismiss her claim against the third defendant. There is no evidence to prove that the third defendant has been personally liable for the injuries of the plaintiff nor was the hospital, for which the third defendant was the superintendent, proved to be negligent or had assaulted the plaintiff.

Against the second defendant, I find the cause of action for negligence proved, but not that of assault. As the second defendant at that material time of the accident was an employee of the fourth defendant, the fourth defendant is vicariously liable to the plaintiff for negligence.

A QUANTUM

It is rather unfortunate that defendants' counsel chose not to make any reference during her initial submission on quantum. Despite request, there was also no reply to the plaintiff's submission. This has deprived this court of valuable assistance especially in assessing damages to be awarded. Thus, B going by the only authorities submitted by the plaintiff this court makes the following award.

General damages

For pain, suffering and loss of amenities, I award a sum of RM200,000. C Though the plaintiff's counsel has submitted a claim for blindness, besides brain injury and quadriplegia, I disallow this for reason that this is associated with the latter.

Special damages

D

Pre trial

1	Cost of diapers at RM17.50 x 5 x 11yrs	RM 962.50
2	Loss of earnings at RM300 x 12 x 11yrs	RM 39, 600.00
3	Cost of nursing care for the plaintiff @ RM400 x 12 x 11yrs	RM 52, 800.00
4	Traveling expenses for relatives to visit the plaintiff at hospitals, cost spend on treatments, purchase of hospitals' and specialist's reports, purchase of a wheel chair	RM 2, 880.40
		RM 96,242.90

Post trial

1	Loss of future earnings at RM300 x 12 x 5yrs	RM 18, 000.00
2	Cost of future nursing care at RM400 x 12 x 12yrs	RM 57, 600.00
3	Cost of purchase of diapers at RM17.50 x 5 x 12yrs	RM 1, 050.00
		RM 76, 650.00

H

Interest

There shall be:

1 Interest at 4%pa on general and special damages (pre trial) from date of issue of writ, ie 10 June 1991 to date of judgement. I

2 Interest at 8%pa on judgment sum from date of judgment to date of realization.

Cost

Cost is awarded against the second and fourth defendant. The plaintiff shall pay the first and third defendants' cost.

Order accordingly.

Reported by Ezatul Zuria Azhari